

Ruben Zapata
March 14, 2007

Good afternoon, my name is Ruben Zapata and I am a Board member of the Naugatuck Valley Project and a member of Sacred Heart/Sagrado Corazon Church in Waterbury. As far back as I can remember, I have interpreted for my parents who came from Puerto Rico and who still don't speak good English. Today, I still interpret for my parents, and for other family and friends.

My stepfather, a native of Puerto Rico, lives in Waterbury and he had a very serious accident as a child that deteriorated into a chronic ulcer on his foot. He speaks limited English and I have to interpret each time he goes to have his ulcer condition maintained. If I hadn't gone and spoken for him to begin with, he would not have gone to the doctor, he would be taking care of his ulcer himself with a straight razor. He deserves quality health care because he is a human being.

As a young boy, I remember how difficult and embarrassing it was to go and interpret for adults. Needless to say I lost time from school as a child. As an adult, I've found myself interpreting for complete strangers in emergency rooms, where I, too, needed medical attention. To see the faces of people who are in pain and who can't communicate to a doctor or nurse really makes me sad. If only there were someone who can help. I've seen people come to emergency rooms who spoke English and witnessed them getting medical attention before the LEP person, even though the LEP person was there first. It's like they are saying, "since you don't speak English, you'll have to wait for an interpreter or bilingual person to show up so we can speak to you". It seems so unethical, cruel, and humiliating.

Today we are faced with a growing immigrating population, many don't speak English well enough to explain what ails them. LEP patients now sit around an emergency room in CT and wait for someone to help them, or maybe the doctor just prescribes some medication that actually makes the matter worse, or maybe the nurse just tells the LEP patient to take some aspirin and call if the symptoms get worse. Whatever the case, the patient is not getting the proper care and could possibly die or spread some kind of public disease. I've heard many stories of women having miscarriages, people having diabetic attacks, and I know people actually die because of no medical interpretation. Had there been a qualified interpreter, of course, this would not happen, but it does happen.

Bishop Peter Rosazza of the Archdiocese of Hartford told a story of a child dying because her parent could not speak English.

As human beings, we all deserve a healthy life and we deserve quality medical interpretation. Medical interpretation is not a privilege, it is a human right, it's a public health issue. We must not assume that the janitor or some receptionist is going to interpret. There are consequences to this: incorrect diagnoses, deaths, the Federal privacy act, law suits and millions of dollars are being lost.

Ladies and Gentlemen, I implore you to please support Senate Bill 1342. Training for medical interpreters is vital.

Thank you.

Jobless rate leads state again Waterbury unemployment rolls rise by 700

Friday, August 18, 2006

BY DAVID KRECHEVSKY

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The Waterbury labor market is back on top -- or bottom, depending on your point of view. The state Department of Labor's figures for July show the 10-town Waterbury region again had the worst unemployment rate in the state, at 5.9 percent, up from 5.3 percent in June. It is a title the market had shed last month following 66 consecutive months of leading the state. For June, the Willimantic-Danielson labor market had posted the state's worst rate, at 5.4 percent. But that region cut its unemployment rolls from 3,100 in June to 3,000 in July, dropping its rate to 5.2 percent.

Waterbury, on the other hand, saw the number of its unemployed rise from 5,400 in June to 6,100 in July.

The state, meanwhile, added 700 jobs in July, but the state unemployment rate still rose slightly from 4.1 percent in June to 4.3 percent. The national unemployment rate for July was 4.8 percent.

The Torrington labor market also saw its rate rise, to 4.2 percent in July from 3.8 percent in June, as 200 people joined the unemployment rolls.

The state's total nonfarm employment in July was 1.67 million, state officials said.

The education and health services industries added 1,200 new jobs, while 1,100 jobs were added both in professional and businesses services and leisure and hospitality.

Until June, the Waterbury area had the state's highest unemployment rate every month since December 2000.

The state's nonfarm employment figures are derived from a survey of businesses and is a measure of jobs in the state; the unemployment rate is based largely on a household survey and measures the work status of people who live in Connecticut.

U.S. Department of Labor Bureau of Labor Statistics

Waterbury Metropolitan Area

Data Series	Back Data	July 2006	Aug 2006	Sept 2006	Oct 2006	Nov 2006	Dec 2006
Labor Force Data							
<u>Civilian Labor Force</u> ⁽¹⁾		102.0	101.4	99.8	101.0	101.3	101.0
<u>Employment</u> ⁽¹⁾		95.9	95.8	94.2	96.1	96.0	96.1
<u>Unemployment</u> ⁽¹⁾		6.1	5.7	5.7	4.9	5.3	4.9
<u>Unemployment Rate</u> ⁽²⁾		5.9	5.6	5.7	4.9	5.2	4.8

Bridgeport Metropolitan Area

<u>Unemployment</u> ⁽¹⁾		20.6	19.4	19.0	16.1	17.5	15.4
<u>Unemployment Rate</u> ⁽²⁾		4.3	4.1	4.1	3.4	3.7	3.3

Danbury Metropolitan Area

<u>Unemployment</u> ⁽¹⁾		3.5	3.3	3.1	2.6	2.9	2.5
<u>Unemployment Rate</u> ⁽²⁾		3.7	3.5	3.4	2.9	3.1	2.7

Hartford and East & West Hartford Metropolitan Area

<u>Unemployment</u> ⁽¹⁾		28.5	27.1	26.7	22.8	24.8	22.6
<u>Unemployment Rate</u> ⁽²⁾		4.8	4.6	4.6	3.9	4.2	3.9

New Haven Metropolitan Area

<u>Unemployment</u> ⁽¹⁾		15.1	14.6	14.5	12.4	13.3	11.9
<u>Unemployment Rate</u> ⁽²⁾		4.9	4.7	4.7	4.0	4.3	3.9

Norwich- New London Metropolitan Area

<u>Unemployment</u> ⁽¹⁾		6.8	6.4	6.3	5.3	5.9	5.6
<u>Unemployment Rate</u> ⁽²⁾		4.4	4.2	4.2	3.5	3.9	3.7

The Willimantic- Danielson market wasn't in this site. But another site gave Windham County rates as follows:

Q1 2006 – 5.9%, Q2 2006 – 4.7 %, Q3 2006 – 5.1%

I don't know what the 4th Quarter was.

Estimates for the Cost of Interpreter Services in the Connecticut Medicaid Program

The total costs for interpreter services within the Medicaid program (\$4.7 million) presented in the Connecticut Health Foundation report (2006) were estimated based on a formula used in a report to Congress by the Office of Management and Budget (2002).

Formula: Total Cost of Interpreter Services =
Percentage of limited English proficient (LEP) Medicaid beneficiaries x

Volume of services used x

Patient-provider interaction time x

Interpreter costs per hour

Deriving the estimates required four steps to estimate each of the four elements on the right side of the equation and a fifth step which involved multiplying all of the four estimates together to arrive at an estimate for the total cost.

Step 1: Estimate the percentage of LEP Medicaid beneficiaries

(1) 487,989 individuals were enrolled in the Medicaid program in 2003

- 366,601 were HUSKY A enrollees (based on data from Connecticut Voices for Children)
- 121,388 were fee-for-service and other managed care enrollees (based on data from the Medicaid Statistical Information System)

(2) Use 2000 Census to estimate the percentage of LEP beneficiaries among HUSKY A enrollees

- 48.7 percent of Spanish-speakers in Connecticut are LEP
- 43.0 percent of speakers of other languages are LEP

(3) 16,793 beneficiaries enrolled in the HUSKY A program were LEP

Within the HUSKY A population:

- 29,113 beneficiaries were Spanish-speaking
- 6,081 beneficiaries reported speaking other languages

Therefore:

- 14,178 Spanish-speaking HUSKY A enrollees were LEP: $29,113 * 0.487 = 14,178$
- 2,615 individuals speaking other languages were LEP: $6,081 * 0.43 = 2,615$

(4) 4.6 percent of all HUSKY A beneficiaries were LEP ($16,793 / 366,601 = 4.6$)

(5) 5,560 fee-for-service and other managed care enrollees were LEP

$$121,388 * 0.046 = 5,560$$

(6) The Medicaid program served approximately 22,353 LEP individuals in 2003 ($22,353 = 16,793 + 5,560$)

Step 2: Determine the volume of services used

See Table B.5 attached for the total service volume for HUSKY A enrollees and Table B.6 for the volume



Languages Spoken by Persons with LEP in Connecticut

Table B.4 presents the list of languages spoken among impoverished Connecticut residents, as well as the number and percentage of persons with LEP.

TABLE B.4

LANGUAGES SPOKEN AND ESTIMATED POPULATION WITH LEP AMONG THOSE LIVING IN POVERTY

	Number of Speakers	Number of Persons With LEP	Percent With LEP		Number of Speakers	Number of Persons With LEP	Percent With LEP
Albanian	1,132	921	81.4	Mandarin	235	50	21.3
Algonquian	24	0	0.0	Miao, Hmong	95	25	26.3
Amharic	111	92	82.9	Mon-Khmer, Cambodian	117	69	59.0
Arabic	621	266	42.8	Navajo	54	21	38.9
Armenian	156	67	42.9	Nepali	56	43	76.8
Bantu	248	60	24.2	Norwegian	108	0	0.0
Bengali	137	9	6.6	Other Asian	20	0	0.0
Bulgarian	180	114	63.3	Other Indic	89	45	50.6
Cantonese	136	17	12.5	Other languages	106	22	20.8
Chinese	1,740	946	54.4	Other Native American languages	36	21	58.3
Choctaw	40	0	0.0	Other Philippine	33	0	0.0
Croatian	122	105	86.1	Other Slavic	22	22	100.0
Cushite	132	132	100.0	Other specified African	18	0	0.0
Czech	89	89	100.0	Pakistan, not elsewhere classified	70	70	100.0
Danish	66	36	54.5	Panjabi	20	20	100.0
Dutch	42	11	26.2	Patois	161	50	31.1
Finnish	15	0	0.0	Persian	76	0	0.0
Formosan	140	49	35.0	Polish	4,158	1,398	33.6
French	4,009	880	22.0	Portuguese	3,959	2,851	72.0
French Creole	1,345	609	45.3	Romanian	121	75	62.0
German	1,787	395	22.1	Russian	1,178	656	55.7
Greek	691	194	28.1	Samoan	104	17	16.3
Gujarathi	259	83	32.0	Serbocroatian	603	502	83.3
Hebrew	312	91	29.2	Sinhalese	17	0	0.0
Hindi	591	197	33.3	Slovak	85	20	23.5
Hungarian	351	135	38.5	South/Central American Indian	53	0	0.0
India, not elsewhere classified	242	185	76.4	Spanish	69,675	33,909	48.7
Indonesian	113	90	79.6	Swahili	18	0	0.0
Irish Gaelic	65	45	69.2	Swedish	197	22	11.2
Italian	4,993	1,485	29.7	Tagalog	267	39	14.6
Jamaican Creole	268	75	28.0	Tamil	154	27	17.5
Japanese	632	370	58.5	Telugu	57	0	0.0
Kannada	41	41	100.0	Thai	201	108	53.7
Korean	975	671	68.8	Turkish	529	178	33.6
Kru, Ibo, Yoruba	231	33	14.3	Ukrainian	345	291	84.3
Kurdish	208	149	71.6	Urdu	345	289	83.8
Laotian	183	77	42.1	Vietnamese	365	220	60.3
Lettish	57	0	0.0	Yiddish	606	86	14.2
Lithuanian	304	149	49.0				
Malay	45	17	37.8	Total	107,206	50,031	46.7
Malayalam	20	0	0.0				

Source: The 2000 U.S. Census Bureau 5 Percent Public Use Microdata Sample (PUMS) files.

Excerpt from "Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients" by the Connecticut Health Foundation, August 2006.

Service Utilization in Managed Care

U.S. Census Bureau estimates were applied to the data on service utilization for HUSKY A enrollees to determine the number of LEP persons using each of five types of services: (1) well-child care, (2) office visits, (3) behavioral health care, (4) emergency visits, and (5) inpatient care (Table B.5). For Spanish-speaking people, the 48.7 percentage estimate of limited English proficient persons was used to determine the share of total visits accounted for by persons with LEP. For visits by people speaking other languages, the 43 percent estimate was used.

Therefore, while the total number of visits is a direct summation of the numbers in the first and third data columns (for example, for well-child care visits, 18,620 visits among Spanish-speaking people plus 3,780 visits for other language groups equals 22,400 total well-child visits), the number of visits restricted to persons with LEP is a weighted summation of the numbers in the first and third data columns ($18,620 \times 0.487 + 3,780 \times 0.43 = 10,693$ or, equivalently, 9,068 visits for Spanish-speaking persons with LEP plus 1,625 visits for limited English proficient persons speaking other languages).

The data indicate that among the total 22,400 well-child care visits by non-English-speaking people, 10,693 were for persons with LEP. For the other categories of service, persons with LEP accounted for 37,532 office visits, 12,126 behavioral health care visits, 11,933 emergency visits, and 2,440 inpatient care stays, of an average of 5.7 days.

TABLE B.5
ESTIMATED NUMBER OF SERVICES USED BY HUSKY A ENROLLEES WITH LEP

	Spanish		Other Languages		Total Volume	
	Total	LEP Only	Total	LEP Only	Total	LEP Only
Well-Child Care	18,620	9,068	3,780	1,625	22,400	10,693
Office Visits	68,230	33,228	10,010	4,304	78,240	37,532
Behavioral Health Care	18,912	9,210	6,782	2,916	25,694	12,126
Emergency Visits	22,426	10,921	2,354	1,012	24,780	11,933
Inpatient Care	3,471	1,690	1,744	750	5,215	2,440
Total Days	20,202	9,838	9,195	3,954	29,397	13,792
Average Length of Stay	5.8	5.8	5.3	5.3	5.6	5.7

Source: CT Voices for Children, 2003 HUSKY A Service Use Data

Excerpt from "Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients" by the Connecticut Health Foundation, August 2006

Service Utilization for Fee-for-Service Recipients

The data on FFS utilization came from the MSIS files and included detailed categories of service. However, because service use data are not broken down by language groups, estimates derived earlier for the overall managed care population (4.6 percent) were applied to estimate the volume of services used by FFS Medicaid recipients with LEP (Table B-6).

TABLE B.6
ESTIMATED MEDICAID SERVICE UTILIZATION BY MEDICAID RECIPIENTS WITH LEP IN FEE-FOR-SERVICE

	Total Number of Services Used	Service Used by Enrollees With LEP
Clinic Services	35,828	1,637
Dental Services	41,141	1,880
Home Health Services	23,092	1,055
ICF/MR	1,406	64
Inpatient Hospital Services	33,202	1,517
Lab and X-Ray Services	76,238	3,484
Mental Health Facility Services	500	23
Nursing Facility Services	40,681	1,859
Other Care	87,298	3,990
Outpatient Hospital Services	96,349	4,403
Other Practitioner Services	50,667	2,315
Prescribed Drugs	123,704	5,653
Physician Services	99,954	4,568
Personal Support Services	33,844	1,547
Sterilizations	241	11

Source: Medicaid Statistical Information System; Centers for Medicare & Medicaid Services 2005b. ICF/MR = intermediate care facilities for the mentally retarded.

Estimated Cost of Providing Face-to-Face Interpreters

One of the most important factors influencing the cost of interpreter services is the average length of the patient-provider interaction. Estimates of the interaction time for various types of services came from three sources: (1) a federal Office of Management and Budget (OMB) report that generated a model for estimating the costs of interpreter services in health care settings (OMB 2002), (2) a literature review of studies on limited English proficient patient interaction time with providers and (3) data that Minnesota's Medicaid program provided on the use and costs of interpreter services for its FFS Medicaid recipients. The OMB report assumes patient-provider interaction times of 10 minutes for emergency room and office-based visits and one hour per day for hospital inpatient stays. Research suggests, however, that the OMB estimates for

office visits are conservative and that people with LEP actually spend between 34 and 47 minutes in examination rooms with providers, for an average of 40.5 minutes (Kravitz et al. 2000; Fagan et al. 2003). Data provided by representatives of Minnesota's Medicaid program offered additional insights into the length of patient-provider interactions. These data are restricted to FFS Minnesota Medicaid recipients²² and include many of the same types of services reported in the MSIS data described above. The data include the unduplicated number of LEP enrollees who received interpreter services the total number of payments made for each service, and the number of units paid (where units were defined as 15-minute increments of interpreter time). These data were used to calculate the average number of hours per claim for use in the cost estimates. For services included in both the Minnesota data and the MSIS files (for example, inpatient hospital services), time estimates from the

Excerpt from "Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients" by the Connecticut Health Foundation, August 2006

Minnesota data files were used because they were the most directly comparable. In other cases, the analysis used the average time for all services as reported in the Minnesota data, the inpatient times from the OMB report, or an average for provider time based on the literature review, depending on the equivalency of the data sources.

The costs of interpreter services for managed care and FFS enrollees were calculated separately. Based on calls to interpreter service providers and figures reported for other states' Medicaid programs, the analysis assumed face-to-face interpreter charges of \$50 an hour. Interpreter costs for each type of service were calculated by multiplying the number

of limited English proficient visits by average interaction time (expressed as portion of an hour) and costs per hour of interpretation time. For managed care enrollees, the analysis assumed 42 minutes of interaction time for outpatient and emergency room visits and one hour for inpatient stays, based on the estimates provided through OMB and a literature review. For FFS recipients, where the types of services were comparable, the time estimates were based on the calculations from the Minnesota FFS data. The analysis used 42 minutes as the standard for outpatient visits in the FFS program when there was nothing comparable from Minnesota's data (see resulting estimates in Table B.7).

TABLE B.7
ESTIMATED COSTS FOR INTERPRETER SERVICES FOR THE CONNECTICUT MEDICAID PROGRAM

	Number of Services Used by Persons With LEP	Interaction Time in Hours	Cost in Dollars Assuming \$50/Hour
Panel 1: Managed Care Enrollees			
Well-Child Care	10,693	0.70	\$374,255
Office Visits	37,532	0.70	1,313,620
Behavioral Health Care	12,126	0.70	424,410
Emergency Visits	11,933	0.70	417,655
Inpatient Days	13,792	1.00	689,600
Total Managed Care Costs			\$3,219,540
Panel 2: Fee-For-Service (FFS) Enrollees			
Clinic Services	1,637	0.70	\$57,307
Dental Services	1,880	0.52	48,884
Home Health Services	1,055	1.01	53,293
Intermediate Care Facilities for the Mentally Retarded	64	1.79	5,751
Inpatient Hospital Services	1,517	0.65	49,313
Lab and X-Ray Services	3,484	1.03	179,430
Mental Health Facility Services	23	1.14	1,302
Nursing Facility Services	1,859	0.88	81,801
Other Care	3,990	1.03	205,460
Outpatient Hospital Services	4,403	0.70	154,110
Other Practitioner Services	2,315	0.70	81,042
Prescribed Drugs	5,653	1.03	291,144
Physician Services	4,568	0.81	185,000
Personal Support Services	1,547	0.89	68,827
Sterilizations	11	2.66	1,465
Total Fee-For-Service Costs			\$1,464,129

Sources: Medicaid Statistical Information System; Centers for Medicare & Medicaid Services 2005b; CT Voices for Children, 2003 Enrollment Data.

Excerpt from "Estimates for the Cost of Interpretation Services for Connecticut Medicaid Recipients" by the Connecticut Health Foundation, August 2006



Improving Medical Interpreter Services in the Naugatuck Valley

Revised May 1, 2006

Following a recent period of rapid immigration, the Spanish-speaking Latino population in the Naugatuck Valley has increased by more than 80% compared to a 58% increase nationally.¹ According to the 2000 census, roughly 7.5% of the residents of the central Naugatuck valley speak English "less than very well."² Taking figures from eight larger cities in the Valley region, there were slightly less than 21,000 speakers of all languages who did not speak English very well.³ An increasing population of non-native English speakers, many of whom have limited English proficiency (LEP), can pose challenges as service providers adjust their practices for users who speak other languages. Challenges are particularly great in the medical setting where timely and accurate transmission of vital information is necessary to prevent serious, even life threatening, error.

A key factor in providing effective care to LEP patients is the use of interpreter services, particularly in hospitals. Generally, healthcare providers have a legal requirement to provide interpreter services to LEP patients. This requirement has as its basis **Title VI of the Federal Civil Rights Act of 1964**, and is treated directly or in the penumbras of several other rules and laws at both the federal and state level including:

- **Executive Order 13166 and subsequent HHS language guidelines**
An order that all federal agencies develop language and cultural competency policies for their service networks, including all hospitals.
- **The Emergency Medical Treatment and Active Labor Act (EMTALA)**
An act that, in part, stipulates rules concerning informed consent and notification around emergency care, requiring effective communication.

- **Connecticut Public Act No. 00-119**
An act to ensure the availability of interpreter services in hospitals including staff notification, signage, policy, and liaison requirements.
- **Connecticut Public Act No. 05-128**
An act requiring patient notification of their rights pursuant to the Medicare conditions of participation, which includes language elements.

Providing superior interpreter services to the LEP population, in addition to satisfying statutory obligations, is in keeping with the hospitals' mission and charitable status. Clinically, steps to increase physician/patient communication and comfort tend to yield better outcomes; a fact the

¹ Cossio-Molina et. al., "Qualitative assessment of the need for medical interpreter services for Spanish speaking residents of the Naugatuck Valley," Abstract No. 110541, American Public Health Association 133rd Meeting & Exposition, Philadelphia, Pennsylvania, December 10-14, 2005.

² Available at <http://www.cogcnv.org/PDF/2000CNVRDemographicProfile.pdf>

³ U.S. Census Bureau, 2004 American Community Survey

Connecticut Hospital Association recently endorsed. A representative of the Association in support of recent state legislation testified that,

“*Effective* communication with health care providers is *essential* in order to obtain *appropriate* treatment. It is *critical* for patients to be able to inform clinicians of their current problems and medical histories in order for clinicians to make appropriate diagnoses and treatment recommendations” (emphasis ours).⁴

Though this testimony was in support of legislating mandating services for the hearing impaired, the fundamental arguments are identical. The clinical effectiveness, and moral case for interpreters, was underscored in a recent *American Journal of Managed Care* report which concluded,

“Studies have shown that overcoming language discordance between patients and providers leads to increased compliance with medications and appointments, fewer emergency department (ED) visits, better recall of information discussed during the encounter, and more questions being asked.”⁵

We estimate the number of LEP residents in the Valley region who might use hospital services to be 32,000. Also the anticipated number clinical encounters (2,226 inpatient stays, 10,061 ER visits, and 31,488 outpatient visits) and the total time of interpreter services (about 37,000 hours) needed for equitable care. The cost of this care will vary by mode of delivery.

Not all available modes of interpretation delivery are appropriate for the Valley’s hospitals. Staff interpreters are perhaps the best overall choice, serving the needs of the patient population most completely. The hospitals might plausibly reduce their costs if they were to hire directly or contract services from a community-based language bank. Such a bank could serve as registry, trainer, and point of dispatch for interpreters and, in an excellent use of available resources, could employ bi-lingual community residents. Video medical interpretation (VMI), an emerging technology, could also be housed in a centralized language bank and bridge the physical distance between area hospitals – though this option is slightly more expensive. Assuming a staff / language bank hybrid:

- After accounting for current spending and offsets, roughly \$500,000 in new spending - across the four hospitals combined - would be needed to provide superior services to the LEP population.
- Particularly if the hospitals pool their financial resources, this level of investment in improved patient care should be feasible, representing only about 0.1% of what the four area hospitals spent on patient care in the past years. A portion of this additional spending could be offset if the state elected to make interpreter services a Medicaid reimbursable service.

⁴ http://www.chime.org/Advocacy/Testimony/SB416_0302.pdf. - A copy of this testimony appears in full in an appendix to this report.

⁵ Cater-Pokras, O, et al. Providing linguistically appropriate services to persons with limited English proficiency: a needs' and resources investigation. *Am J of Manag Care*. 2004;10:SP29-SP36.

Hospitals find translators a draw for patients

▶ INTERPRETERS

Continued from Page B1

ing opportunity out of what many in health care initially saw as an onerous government requirement. Under a state law passed in 2000 and a federal ruling issued this year, hospitals must provide trained medical interpreters for every patient who needs them, no matter how obscure the language. Hospitals groaned, saying the interpreters would be expensive and hard to find. But now, some are finding that a relatively small investment brings in new patients.

Since 1995, when Gristan became St. Elizabeth's first full-time Russian interpreter, annual Russian-speaking patient visits have jumped from 500 to more than 17,000 last year. Spurred by Gristan's services and a growing team of Russian doctors and nurses, the hospital has made its first serious inroads into the Russian community that surrounds its Brighton campus — and now rivals much larger Beth Israel Deaconess Medical Center, with 13,000 visits, as the go-to hospital for Russians.

Other hospitals have found their own language niches: Mount Auburn has become known for serving Armenians; Boston Medical Center, with the state's largest program, attracts many immigrants, among them Kurds and Somalis; Tufts-New England Medical Center, near Chinatown, draws Chinese patients; and Portuguese speakers come from as far away as Worcester and Fall River to Cambridge Hospital. Smaller suburban hospitals have had success, too: the language program at Everett's Whidden Memorial Hospital drew 2,979 patients last year

and is on pace to attract twice that many this year.

St. Elizabeth's Russian program costs \$225,000 a year for four full-time interpreters and six per diems. Since the state law took effect, the hospital spends an additional \$130,000 a year for 24-hour on-call interpreters for all languages. The hospitals say they haven't calculated how much the program has added to revenue.

At St. Elizabeth's, doctors and nurses credit the interpreters not only with bringing in business, but sometimes with saving lives. Patients often call the interpreters first, the interpreters triage them either to the emergency room or to a specialist. Doctors and nurses stop interpreters in the hall to quickly explain something to a patient. Gristan calls cabs, locates family members, straightens out bureaucratic messes.

Sometimes, in a health care environment that is increasingly technical, confusing, and often frustrating, English-speaking patients wish they had such advocates. Often, said interpreter Alla Shevelyova, the patient in the next bed says, "Maybe you could explain it for me also — I'm jealous!"

The St. Elizabeth's team — which also includes Yelena Polyakovakaya, who was a neurologist in Moscow; and Lena Ivitskaya, a former elementary school teacher — works hard to bring Russian influences into the hospital, from their posters of St. Petersburg to their crib sheets translating 12 different words for pain — shooting, throbbing, burning, and so on.

In the hilltop lobby of the Catholic hospital, a Cyrillic sign urges patients to pick up a dedi-

cated black phone for an interpreter. Prowling the halls, Gristan tries to spot Russian speakers by sight, then approaches them to see whether they need help. Relying on instinct, she is rarely wrong. "You feel it," she said.

The interpreters translate not only language but attitudes about medicine, life and death, even some of the pessimism many Russians admit to. "Has she had good health generally?" becomes "What sicknesses do you have?"

They explain Russian home remedies — mustard plasters, bandaging a leek onto an abscess to make it drain — and account for Russian medicine's more paternalistic approach to bad news. When Russian families ask her to hide a diagnosis from the patient, Ivitskaya refuses, but tells the patient very carefully, especially if it's cancer. "You can kill with that word," she said.

Yet unlike many Americans, Russians don't avoid the doctor when they have symptoms, said Margaret Sullivan, a nurse.

Gristan, 50, says her clients' pain isn't always physical. Her clients include physicists, professors, a journalist who photographed Yuri Gagarin's first space flight. Mostly Jewish, they left Russia fearing discrimination and, later, the chaos of the Soviet Union's fall — and few have regained the professional status they had at home.

Gristan understands. She was a doctor at a maternity hospital in St. Petersburg, but when she emigrated in 1989, she opted out of the grueling requirements for a US doctor's license. Last week, however, she spoke with a doctor's authority, peppering Leonid Fin-

kelstein with instructions as he walked on a treadmill.

"Hold on tight," she said. "Don't look down — look straight ahead. If something hurts, tell us right away."

"I'm not sorry" about not being a doctor anymore, she said. "I'm helping people this way."

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LOOKING RIGHT AHEAD
If something hurts, tell us right away.

OLGA GRISTAN
A Russian translator at St. Elizabeth's Medical Center, speaking to a patient



GLOBE STAFF PHOTO/JANET KNOTT

Olga Gristan on hand to translate for Leonid Finkelstein, a St. Elizabeth's Medical Center patient.

Patients get a voice

12/16/03

Hospital translators good for clients and for business

By Anne Barnard
GLOBE STAFF

She trained as a cardiologist in Russia, but lying in a hospital bed in pain and shaky at speaking English, Yevgenia Lanina felt helpless as she faced a group of young doctors.

They were saying — as near as she could tell — that her surgeon had left on vacation, and that doctors she didn't know were now in charge.

Rescue arrived in the form of Olga Gristan, head of a team of Russian Interpreters at St. Elizabeth's Medical Center. She figured out that Lanina had misheard; the surgeon would show up as

planned.

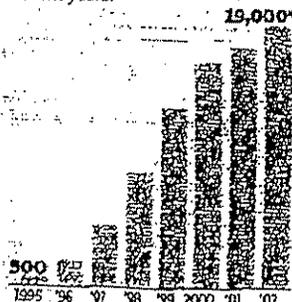
But Gristan didn't just clear up the miscommunication. She also relayed Lanina's request that a nurse take her temperature. She even got the joke when Lanina said the momentary scare made her feel like *nechya babushka*, "nobody's grandmother." Gristan giggled at the reference to a story by the Soviet satirists Ilf & Petrov.

"We're from one culture. She always understands," Lanina, 74, said in Russian. She said she urges her Russian neighbors in Methuen to switch to St. Elizabeth's despite the 40-minute drive.

St. Elizabeth's is one of several hospitals that have made a market-

Russian patients

The number of Russian patients treated at St. Elizabeth Medical Center has increased steadily in recent years:



* extrapolated
GLOBE STAFF GRAPHIC

HOSPITALS

R_x for Communication

IMAGINE YOU'RE WRITHING in pain in an ER but unable to communicate with the doctor. It happens all too frequently, as growing numbers of non-English speakers land in hospitals that lack interpreters. In response, hospitals are turning to videoconferencing systems that connect

lar systems. In northern California, four hospitals banded together to form the Health Care Interpreter Network, using videoconferencing equipment to share their staff interpreters. Holy Name Hospital in New Jersey, which subscribes to a service like LAN's, plans to equip ambulances



HEAR ME NOW? Staffers demonstrate a new system

'We don't have to play charades in the hospital anymore.'

health-care workers and patients with faraway translators. Mercy Hospital in Miami unveiled a new interpreting service created by Language Access Network. A doctor will be able to call LAN's translation center in Columbus, Ohio, at any hour of the day, pick among 150 languages—including a range of Chinese dialects and American Sign Language—and gain access to an interpreter who pops up on a screen.

Other hospitals around the country have introduced simi-

lar systems. In northern California, four hospitals banded together to form the Health Care Interpreter Network, using videoconferencing equipment to share their staff interpreters. Holy Name Hospital in New Jersey, which subscribes to a service like LAN's, plans to equip ambulances with new units that will provide translation services at accident sites. Those who have used the videoconferencing technology say it's a vast improvement over telephone interpreting services, which require handing the phone back and forth and can be awkward. And the technology is cheaper than an army of staff interpreters. But most important, says Holy Name's John Hirsch, "we don't have to play charades in the hospital anymore."

—CARMEN GENTILE and CHRISSEY BALZ

BELIEFWATCH Spirit Filled



SUNDAY MORNING: At a Pentecostal church in Memphis, Tenn.

BY LISA MILLER

What does it mean to speak in tongues? And who has the right, or the privilege, to do so? These questions, largely theological, have lingered at the fringes of American Protestantism. Now, as charismatic Christianity sweeps the country and the world, speaking in tongues has become as divisive as it is popular.

Earlier this fall, in a sermon at Southwestern Baptist Theological Seminary in Ft. Worth, Texas, a pastor named Wm. Dwight McKissic mentioned that he sometimes speaks in tongues while privately praying to God. "I did it this morning," he told NEWSWEEK. After that sermon, Southwestern's president, Paige Patterson, took the extraordinary step of removing the video of McKissic's speech from the seminary's Web site. Then, after a vote by the school's board, Patterson issued a controversial statement saying that Southwestern would not hire anyone who advocated the use of tongues in prayer.

Although Southern Baptists have no official policy against it, speaking in tongues is something the denomination has "always resisted" as un-Biblical, explains Patterson.

Go to Xtra.Newsweek.com to see Beliefnet's first-person account of speaking in tongues. beliefnet.com

But Patterson is fighting an uphill battle, and he knows it. According to a recent Pew survey, nearly 20 percent of American Christians speak in tongues more than several times a year. According to a survey by Baylor University, 37 percent of Americans say their place of worship would encourage or allow speaking in tongues. A growing number of Roman Catholics now speak in tongues, as well as Episcopalians, Lutherans—and, despite the denomination's historical resistance, Baptists.

Speaking in tongues has traditionally been seen as a gift, a sign that a person is filled with the Holy Spirit like the babbling Christians in the Book of Acts, but until recently it was common only in Pentecostal denominations like the Assemblies of God. Fundamentalists were against it; no one but the first Christians spoke in tongues, they said. Now, as the lines between denominations break down and people seek more emotional ways to connect with God, speaking in tongues "provides an immediacy of religious experience," says Randall Balmer, religion professor at Barnard. "It provides a voice to people who feel they have no voice." With heads thrown back and voices ululating in haunting communion, the spirit-filled "speakers" defy rational church officials to legislate against them.

LANGUAGE: Area hospitals

look for cooperative solutions

Continued from 1B

the more than 40,000 non-English-speaking immigrants living between Ansonia and Torrington.

Representatives from each hospital — Griffin in Derby, Charlotte-Hungerford in Torrington, and Saint Mary's and Waterbury hospitals in Waterbury — agreed at the meeting that language could be a barrier to adequate health care.

They agreed to work with each other, legislators and the Naugatuck Valley Project to develop a solution for medical interpretation, and to begin to do so at a roundtable discussion within the next 30 days.

"We do believe that collaboration between the community and the hospitals is the most efficient way to bring about a change," said Alan Maranacio, chairman of Charlotte-Hungerford's diversity committee.

A study commissioned by Naugatuck Valley Project found that the number of people in Seymour, Ansonia and Derby with limited English proficiency tripled from 1990 to 2000. There was an increase of 25 percent in Waterbury and 15 percent in Torrington.

Connecticut law requires hospitals to provide medical care for people in their own language when the percentage of the limited-English-proficiency population is more than 5, said Michael Miller of Community Catalyst, a national

healthcare advocacy group based in Boston.

All four hospitals in the Naugatuck Valley provide translation services, though not with face-to-face interpreters.

Charlotte-Hungerford and Waterbury use Language Line, while Saint Mary's and Griffin use Cyracom.

Both services provide around-the-clock access by telephone to translators able to provide translation in more than 200 languages.

Hospital staffers at all locations call an 800 number. In some cases, employees use a dual handset with the staff person on one end and the patient on the other, both talking to a translator.

In other cases, the staff person and patient need to pass one handset back and forth.

John Tobin, president and CEO of Waterbury Hospital, said in a statement Tuesday that his organization "is committed to providing translation services to those patients that need it. ... As much as we like the human touch a face-to-face translator might provide, Language Line is very comprehensive in terms of languages, uses translators familiar with medical terminology, and is affordable. ..."

T.J. Senker, vice president of operations at Saint Mary's, echoed Tobin's statement in a separate conference call Tuesday.

However, during focus groups with more than 200 people earlier this year, the Naugatuck Valley Project

discovered that many non-English speakers were either not aware that translation services existed, or were not comfortable using them.

"My mother was uncomfortable with the translation service because the translator spoke a different kind of Portuguese," said Isabel Lagoas of Waterbury.

"I noticed such a difference in her when someone on staff was found who could speak the right Portuguese to her face to face."

Ken Roberts, director of communication at Griffin Hospital, said the Derby hospital is assigning a Spanish-speaking employee to spend 20 hours a week interpreting for Hispanic patients.

The employee also will complete a 50-hour medical interpreter class to become certified.

"The Spanish-speaking population is growing rapidly in the Valley and we wanted to be responsive to this need for medical interpreting," said Roberts. That employee's time will be scheduled before admissions or surgeries, said Roberts, to maximize her effectiveness.

Ginny Potrepka, patient advocate at Waterbury Hospital, said the hospital would consider using face-to-face interpreters for specific purposes, like scheduled pre-admission or teaching classes. Senker said Saint Mary's is looking into furthering the language skills of some of its employees.

Forum sees need for hospital translators

5/11/06

BY ED DITKO
REPUBLICAN-AMERICAN

WATERBURY — When a patient who doesn't speak English seeks care at a hospital in the Naugatuck Valley, something is lost in the exchange. Often what is lost is the quality of care.

Isomar Vazquez, a freshman at Wilby High School, had to serve as an unofficial translator when her mother needed care. "When I have to translate, I don't tell my mother everything the doctor says, and my mother doesn't tell me everything

that is bothering her," said Vazquez. Some of the issues that need to be talked about between doctor and patient can be "embarrassing" for a 15-year-old, she said.

There were nods of agreement and looks of understanding on the faces of several people Wednesday night in the crowd of more than 250 during a forum held by the Naugatuck Valley Project. The organization is calling on area hospitals to provide trained medical, face-to-face translators for

See LANGUAGE, Page 2B